DISTINGUISHING BETWEEN CONCEPTUALIZATIONS OF ATTACHMENT: CLINICAL IMPLICATIONS IN MARRIAGE AND FAMILY THERAPY

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ABSTRACT: Authors described four distinct conceptualizations of the construct of attachment and identified clinical implications associated with each. Three of the conceptualizations, which are influenced by the work of Bowlby and Ainsworth, seem to have some empirical support; these conceptualizations are compatible with systemic and social constructionist approaches to family therapy. The other conceptualization—Reactive Attachment Disorder (RAD)—contradicts the extensive body of literature associated with the Bowlby/Ainsworth traditions and tends to pathologize children. Therefore, family therapists interested in attachment are encouraged to maintain conceptual clarity in their clinical work and are further encouraged to rely on clinical conceptualizations and interventions that are consistent with the work of Bowlby and Ainsworth.

KEY WORDS: attachment; Bowlby; Ainsworth; Reactive Attachment Disorder; family therapy.

There seems to be an increasing clinical interest in "attachment" but there are at least four distinct conceptualizations that feature

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different clinical implications, so it seems important to distinguish among these conceptualizations. Some ubiquitous social science constructs that become part of casual conversation—such as "identity," "ego," "self-esteem"—may impede research and clinical conceptualization because "of the deceptive impression that everyone already knows what [it is] . . . there is a tendency to treat the concept as an independent given" (Wells & Marwell, 1976, p. 9). Clarity may also be impeded if the same term is used to refer to different constructs that are operationalized and researched independently (Werner-Wilson & Murphy, 1999).

"Attachment" is a term that lacks conceptual clarity for both of these reasons. First, it is a ubiquitous term that has become a part of the casual lexicon to refer to a sense of closeness in a relationship or toward an object. Second, various meanings of attachment have developed across social science specialties to refer to (a) a diagnostic disorder, (b) parent-child relationship, (c) adult nuclear family attachment, and (d) adult romantic attachment. We will distinguish among these four professional uses of the term in order to help promote conceptual clarity in clinical application.

ATTACHMENT AS A DIAGNOSTIC DISORDER: REACTIVE ATTACHMENT DISORDER

There seems to be increasing interest in the Reactive Attachment diagnosis, including interest by clinicians who may be unaware that the recommended treatment—referred to as "holding therapy" or "attachment therapy which will be described later—contradicts research on attachment. The distinguishing feature in this conceptualization of attachment is the belief that some children are incapable of attachment.

> The "psychiatric diagnosis of 'reactive attachment disorder of childhood' (with inhibited and disinhibited subtypes) has been loosely informed by attachment research findings (but not as much as it should be—Zeanah, 1996), the validity of the diagnosis remains largely untested" (Rutter & O'Connor, 1999, p. 833).

Reactive Attachment Disorder of Infancy or Early Childhood is described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-R) as a "markedly disturbed

and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (American Psychiatric Association 2000, p. 127). Two manifestations are described: inhibited type and disinhibited type. Inhibited type is demonstrated by "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses" (American Psychiatric Association 2000, p. 130). Disinhibited type refers to "diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers)" (American Psychiatric Association 2000, p. 130).

According to the DSM-IV-TR, reactive attachment disorder (RAD) is associated with "pathogenic care" that includes at least one of the following: (a) persistent disregard for basic emotional needs for comfort, stimulation, and affection; (b) persistent disregard for basic physical needs; (c) repeated changes of primary caregiver.

Prevalence of Reactive Attachment Disorder

THE DSM-IV-R, noting that epidemiological data are limited, reports that Reactive Attachment Disorder is "very uncommon" (American Psychiatric Association, 2000, p. 129), but some recent sources have directly suggested or indirectly implied that Reactive Attachment Disorder is relatively widespread. For example, one recent article carries the following claim about prevalence:

> Reactive Attachment Disorder is quite common: there are approximately one million children with RAD in New York City alone (Karen, 1990). The National Adoption Center reports that 52 percent of adoptable children have attachment disorder symptoms. Twenty percent of the children under five who visit Kaiser-Permanente in Southern California show RAD symptoms (Brill-Downey, 1994) (Reber, 1996, p. 27).

Of the three sources cited for prevalence, one is from the popular periodical *Atlantic Monthly* (Karen, 1990), one is unsubstantiated information from an adoption organization, and one is from a personal communication to Reber that is ostensibly anecdotal.

Other sources indirectly imply that Reactive Attachment Disorder is widespread by citing statistics about insecure attachment when discussing attachment disorder. For example, "as many as 30% of children

develop insecure attachment relationships with their parents. Insecure attachment may take the form of avoidant, distant behavior or anxious clinging behavior" (Booth & Wark, 2001).

Clinical Implications of Reactive Attachment Disorder

The description of RAD in the DSM would suggest that some form of family therapy would be the treatment of choice since it is associated with "pathogenic care," but most of the current clinical writing takes an individualistic approach in which the child is the primary target of clinical intervention. Treatment of RAD is typically based on the assumption that the client has repressed rage that interferes with ability to form an attachment, so clinical interventions are designed to help the child release his or her rage and teach the child that parents can and will be in control.

Holding therapy (sometimes referred to as attachment therapy) is the primary form of treatment recommended for RAD. This is a controversial (and sometimes fatal) approach to treatment of children with RAD. It includes three primary treatment components that are directed toward the child: (a) prolonged restraint for purpose other than protection; (b) prolonged noxious stimulation (e.g., tickling, poking ribs); and (c) interference with bodily functions.

Although proponents of holding therapy contend that it has been misrepresented (e.g., they suggest that it is also nurturing and sensitive), effectiveness seems to be based on anecdotal testimonials from parents. "[T]he fact remains that there is simply no empirical evidence at present to support the assertion that attachment therapy is more effective, or even as effective, compared to accepted and conventional approaches" (Hanson & Spratt, 2000, p. 142). Further, "Parents may be told that this is the only way to keep their child from becoming a serial killer, murderer, or psychopath" (Hanson & Spratt, 2000, p. 142).

CONCEPTUALIZATIONS OF ATTACHMENT INSPIRED BY JOHN BOWLBY

The remaining three social science conceptualizations of attachment are directly related to the work of John Bowlby and Mary Ainsworth who were the two major pioneers in the area of attachment. The three conceptualizations include (a) attachment in children, (b) adult nuclear family attachment, and (c) adult romantic attachment. In each

case, there seems to be clear empirical support for the conceptualization.

ATTACHMENT IN CHILDREN

The pioneering work on attachment in children by Bowlby (1958; 1969/1982; 1988) and Ainsworth (1989) has generated the most consistent theoretical and empirical attention of all of the conceptual traditions associated with attachment. This scholarship on attachment in children seems to offer important clinical implications for family therapists. John Byng-Hall, a family therapist who worked with Bowlby at the Tavistock Clinic, has published several works describing the clinical relevance of Bowlby's work to family therapy. Byng-Hall suggested that Bowlby wrote one of the first manuscripts about family therapy in 1949 and, according to Byng-Hall, Bowlby was a "steadfast supporter of family therapy" (Byng-Hall, 1999, based on Byng-Hall, 1991).

Bowlby suggested that attachment with an adult caregiver ensured the safety of children. In contrast to proponents of RAD, Bowlby firmly suggested—and empirical research seems to support his assertion—that all children form an attachment with their caregivers. Jude Cassidy recently provided a succinct yet thorough overview of attachment theory. According to Cassidy (1999), Bowlby distinguished among three aspects of attachment: (1) attachment behavior, (2) attachment bond (this is the aspect of attachment almost exclusively emphasized by casual readers of Bowlby and by proponents of RAD), and (3) attachment behavioral system. The first, attachment behavior, refers to actions that promote proximity to an attachment figure. Children make eye contact, cry, or make gestures as methods to engage their parents. Attachment behavioral system refers to a particular repertoire of behaviors that an individual uses. Attachment bond refers to an affectional tie: "this bond is not between two people; it is instead a bond that one individual has to another individual who is perceived as stronger and wiser . . . A person can be attached to a person who is not in turn attached to him or her" (Cassidy, 1999, p. 12). Cassidy reported several important propositions about attachment theory:

1. The attachment bond is only one feature of a parent-child relationship. Caregivers also serve as playmates, teachers, and disciplinarians.

2. A child may demonstrate attachment behavior with someone for whom they do not share an attachment bond.
3. Children experience multiple attachments but the quality of the attachment bond is not the same in each relationship. The quality of the bond is influenced by amount of interaction, quality of care provided, and emotional investment of the caregiver.

Other Behavioral Systems

The following material is based on Cassidy's (1999) review of the attachment literature. Bowlby suggested that an attachment behavioral system served an evolutionary function because it encouraged protection of children who are dependent on adults for safety. Bowlby also suggested that there are two other behavioral systems that interact with the attachment behavioral system. First, the exploratory behavioral system promotes survival because curiosity helps children learn about and adapt to their environment. This system reduces attachment behavior. Second, the fear behavioral system promotes safety and, as a result, engages the attachment system.

Family as a Secure Base

From a family systems perspective, Byng-Hall suggests that the family contributes to attachment by providing a secure family base which is defined as "a family that provides a reliable and readily available network of attachment relationships, and appropriate caregivers, from which all members of the family are able to feel sufficiently secure to explore their potential" (1999, p. 627). Byng-Hall suggests that there are two factors associated with a secure family base. First, he suggests that there is a shared awareness that attachment relationships are important and care for others is a priority in the family. Second, he contends that family members should support one another in providing care for each other.

Internal Working Model

Bowlby suggested that experiences with caregivers influence expectations about future relationships. He referred to these expectations as an internal working model that influences attachment style in children. Working models seem to be "based on a network of developing representations that emerge successively but interactively with age"

(Thompson, 1998, p. 267). Early representations provide important information but they are fairly simplistic and " probably do not provide the conceptual foundation for the sophisticated and complex representations of self and relationships in other years" (Thompson, 1999, pp. 267–268). Caregivers not only influence attachment by the quality of care they provide but also by the interpretation of that care because their interpretation may be adopted by the child. Thompson (1999) concludes that, for these reasons, it is important to consider working models in a developmental context in order to understand them as a source of developmental continuity.

Styles of Attachment

Internal working models, which are tested and revised, influence attachment style. Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) noticed that during play children frequently interrupted their play behavior to literally touch base with their caregiver before returning to their play. Ainsworth suspected that this behavior represented the interconnectedness between the exploratory and attachment behavioral systems. Ainsworth developed the Strange Situation (SS) test to evaluate types of attachment (Ainsworth, Waters, & Wall, 1978); assessment of attachment style was also based on observation of children in their home environment. In the SS, Ainsworth examined the response of children to a strange situation: children in her laboratory (the strange situation) were briefly separated from their parents twice, once for three minutes and once for six minutes. Behaviors of the parents and children were observed prior to separation and after each separation. Four styles of attachment have been developed based on research using the SS test: secure, avoidant, resistant or ambivalent, and disorganized/disoriented (Ainsworth, Waters, & Wall, 1978; Main & Solomon, 1990). Material about the first three categories is based on the work of Mary Ainsworth and her colleagues. The material about the final category is based on the work of Main and Solomon.

Secure attachment. Most children in the general population (estimates range from 50% to 75%) can be classified as securely attached. During the SS test, the child explores the room prior to separation and shows distress when the caregiver leaves. When they are reunited, both the caregiver and the child seem pleased to see each other and begin to interact. Home observation identified the following characteristics associated with parent-child interactions:

- Communication between the caregiver and the child seems to be warm and sensitive. the child does not seem afraid to express anger.
- The caregiver permits age-appropriate autonomy and exploration. There is flexibility in proximity: The child and caregiver operate independently and touch base with each other from time to time.
- The caregiver seems to have a coherent view of attachment and recognizes that it is important to the child.
- The caregiver and the child seem to have fun interacting.

Avoidant attachment. In the general population, 15% to 30% of children can be classified as avoidant. During the SS test, the child continues to explore the room after separation showing limited, if any, distress. When the caregiver returns, the child turns away from the caregiver and moves toward a toy in the room. The caregiver pays more attention to objects in the room than the child. If the child is picked up by the caregiver, she or he makes motions to be put down. Although behaviors suggest that the child is unaffected by the separation, research suggests that they remain aroused much longer than securely attached children: the avoidant child continues to show physiological signs of anxiety. The strategy to withdraw from the caregiver despite physiological arousal suggests that the child is attempting to deactivate feelings of insecurity by focusing on other objects. Home observation identified the following characteristics associated with parent-child interactions:

- The caregiver seems to respond negatively to the child's attempts to make contact: the caregiver withdraws when the child is sad.
- The caregiver seems to demonstrate more rejecting behaviors toward the child.
- The child demonstrates more anger at home than in the lab setting.
- Play behavior seems to serve as a distraction from attachment needs.

Resistant or ambivalent attachment. Byng-Hall (1995) has suggested that these relationships are similar to enmeshed relationships. The child seems to cling to caregivers because of experiences in which the caregiver is intermittently unavailable (Byng-Hall, 1995). In the general population, from 4% to 25% can be classified as resistant or avoidant. During the SS test, children appear to be distressed prior

to the two separations and seems preoccupied with their caregiver throughout the procedure. They do not seem to be soothed by the presence of their caregiver and may appear angry or passive. The child is unlikely to return to exploration after a reunion. Home observation identified the following characteristics associated with parent-child interactions:

- The caregiver seems committed to the task of nurturing but is often emotionally unavailable.
- The child seems to have learned that their caregiver is capable of responding if she or he is persistent at seeking attention so the child stays in close proximity to the caregiver.
- Some children may take care of their parent as a way to foster interaction. This may, according to Byng-Hall (1995), contribute to parentification of children.

Disorganized/disoriented attachment. In the general population, 15% to 25% of children can be classified as disorganized/disoriented. Research suggests that a significant number of children (as many as 80%) who are maltreated can be classified in this category. Main and Solomon (1980), in coding videotapes of the SS test, experienced difficulty classifying all children using the previous three categories because some children did not respond systematically to the reunion part of the experience. In the presence of caregivers, these children may (a) freeze with a trance-like expression, (b) rise when caregivers enter the room; (c) fall to the floor; or (d) cling to caregiver while leaning away from caregiver. Their other behaviors could be classified into one of the other categories. Observations of these children at home suggest that the idiosyncratic response to the SS test may be related to the way the child avoids abuse at home. For example, a child who cowers in the floor in the SS test may have cultivated this cowering behavior as a way to protect herself or himself from injury.

Because attachment in children seems to be strongly influenced by parenting, a discussion of clinical implications will be presented after the next section in which we review adult nuclear family attachment and its' relationships to attachment in children.

ADULT NUCLEAR FAMILY ATTACHMENT

Research on attachment styles in children inspired investigation of attachment styles in adults. An Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) was developed to assess attachment

styles in adults and has been revised three times. During the AAI, the participant is asked to provide five adjectives that describe each parent and an example of an episode that illustrates each adjective. Interviewers inquire about the following: (a) how caregivers responded to them when s/he was upset; (b) whether caregiver threatened her or him; (c) whether she or he felt rejected; and (d) explanation for caregivers behavior; and (e) the effect of these childhood experiences on her or his adult personality.

The attachment of the participant's children can be predicted from these interviews. The responses are evaluated on two dimensions. The first dimension, coherence, refers to answers that (1) provide a clear and convincing description; (2) are truthful, succinct, and complete; and (3) are presented in a clear and orderly manner. The second dimension is the ability to reflect on the motives of others. Four types of adult attachment have been identified: secure/autonomous, dismissing, preoccupied, and uninvolved/disorganized. We will rely of the work of Main, Kaplan, and Cassidy (1985) and Byng-Hall (1995) to describe these important categories.

Secure/Autonomous Adult Attachment

Research using the AAI suggests that caregivers seem to be able to respond appropriately to children if they can make sense of their own childhood experience and are able to understand the motives of others. This seems to facilitate secure attachment in their children. As a caregiver, the person seems to recognize that attachment is important. This type of attachment promotes secure attachment in children.

Dismissing Adult Attachment

Responses on the AAI are not coherent: adjectives used to describe caregivers are usually positive but descriptions either do not support the positive adjective or actively contradict it. The person seems to be dismissive about the importance of attachment. This type of adult attachment promotes avoidant attachment in children. "The shared parent/child attachment strategy is to maintain distance . . . in order to reduce the likelihood of emotional outbursts that might lead to rejections. The price is a loss of sensitive care for the child when it is needed" (Byng-Hall, 1995, p. 50).

Preoccupied Adult Attachment

Response on the AAI are not coherent: descriptions of adjectives include vague references. The person seems to be preoccupied with past relationship experiences and may appear angry. As a result, boundaries in the family become blurred. This type of adult attachment promotes resistant or ambivalent attachment in children. "There is a great deal of mutual monitoring and mind reading, all in an attempt to forestall any potential drifting away on the part of either the parent or the child" (Byng-Hall, 1995, p. 50).

Unresolved/Disorganized Adult Attachment

This person seems frightened by the memory of past trauma which may promote momentary disassociation. Responses on the AAI about topics that deal with loss or abuse are incoherent. For example, the person might use language suggesting that someone who is deceased is still alive. Other responses are consistent with the other categories. This type of adult attachment promotes disorganized/disoriented attachment in children. "The general impression is that the parent does not have the child in mind at all but, rather, is scripting the child into some past drama . . . As the children grow older, overall strategies do seem to evolve. They either become more controlling of the parent, often in a punitive way, or they become caretaking of their parents" (Byng-Hall, 1995).

CLINICAL IMPLICATIONS OF ATTACHMENT IN CHILDREN AND ADULT NUCLEAR FAMILY ATTACHMENT

In contrast to holding therapy that is based on the notion that children are unable to form attachments, clinical interventions based on Bowlby's conceptualizations are more systemic. First, clinicians should assess the relationship between children and multiple caregivers, recognizing that children may demonstrate a different attachment style with mothers versus fathers (as well as stepparents). Second, interventions should be designed that attend to internal working models associated with different attachment styles. For example, holding therapy or punitive approaches (e.g., boot camps) would seem to be contraindicated for children who demonstrate an avoidant attachment style

(which may be misdiagnosed as RAD) because it would confirm an internal working model that caregivers are punitive.

Based on Bowlby, Byng-Hall (1995, 1999) identified four general tasks for the family therapist to perform to address attachment. Each of the tasks may be addressed from any number of approaches to family therapy.

- Provide a secure therapeutic base for the family.
- Work with current significant relationships.
- Explore the relationship between family members and the therapist.
- Review and evaluate ways in which current relationship patterns are influenced by past experiences.

ADULT ROMANTIC ATTACHMENT

Adult romantic attachment is based on the following assumption: "romantic love is fundamentally an attachment process through which affectional bonds are formed" (Simpson & Rholes, 1998, p. 6). Measurement relies primarily on self-report instruments to assess perception of current relationship experiences with peers or romantic partners. Research suggests that there is limited correspondence between AAI and measures of adult romantic attachment. Simpson and Rholes (1998) suggest that lack of correspondence should not be surprising because they measure different dimensions of attachment: "the two traditions should provide unique information about an individual's attachment history in different kinds of relationships experienced at different points in time" (1998, p. 6). In other words, the AAI measures perception of relationship with parents to predict caregiving while measures or peer/romantic attachment assess contemporary relationships with other adults.

These two conceptual traditions also feature different data collection methodologies (e.g., self-report versus observational) that do not often correspond because they seem to measure different perceptions (e.g., insider versus outsider views). From the peer/romantic partner tradition, attachment is conceptualized as a continuous rather than a categorical variable. Also, identification of two forms of avoidant attachment in adult romantic relationships was a divergence from nuclear family tradition. Attachment is based on view of self and others:

Secure: a positive view of self and others.
Preoccupied: negative self-views and positive (yet apprehensive) views of others.
Fearful-avoidant: negative views of self and others.
Dismissing-avoidant: positive self views but negative views of others.

CLINICAL IMPLICATIONS OF ADULT ROMANTIC ATTACHMENT

It would seem that attention to adult romantic attachment would be best addressed in conjoint couple therapy rather than family therapy. A series of recent articles by Susan Johnson and her colleagues (Johnson & Greenberg, 1995; Johnson, Makinen, & Millikin, 2001; Johnson & Whiffen, 1999) suggest that emotionally focused therapy for couples is well suited to dealing with adult romantic attachment. The following tasks would address issues associated with attachment between couples:

- Investigation of the influence of internal working models on communication and relationship patterns, trust, and intimacy.
- Discussion of security in the relationship.
- Identification of potential mismatches between attachment styles (e.g., one spouse exhibits a fearful-avoidant style while her or his partner exhibits a preoccupied style).
- Inquiries about attitudes toward self and others.

SUMMARY

Because of an increased clinical interest in attachment, we have described four distinct conceptualizations of this construct and identified clinical implications associated with each. The following three conceptualizations, which are influenced by the work of Bowlby and Ainsworth, seem to have empirical support: (a) attachment in children, (b) adult nuclear family attachment, and (c) adult romantic attachment. These conceptualizations are compatible with systemic and social constructionist approaches to couple and family therapy interventions. The fourth conceptualization—Reactive Attachment Disorder (RAD)—which includes some references to the work of Bowlby and Ainsworth,

includes clinical interventions that contradict the extensive body of literature associated with the Bowlby/Ainsworth traditions and tends to pathologize children. Therefore, family therapists interested in attachment are encouraged to maintain conceptual clarity in their clinical work and are further encouraged to rely on clinical conceptualizations and interventions that are consistent with the work of Bowlby and Ainsworth.

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